The Life of a Workers' Compensation Claim

Employer's Responsibilities

Labor Code 5401

- The Employer will PROVIDE (in person or by mail) an *Employee's Claim Form for Workers' Compensation Benefits* (DWC-1/STATE FUND 3301) within one working day of their knowledge of injury
- Should NOT be completed by the supervisor
- Knowledge is when any supervisor or lead person has been told of or witnesses the injury


State Compensation Insurance Fund

STATE FUND

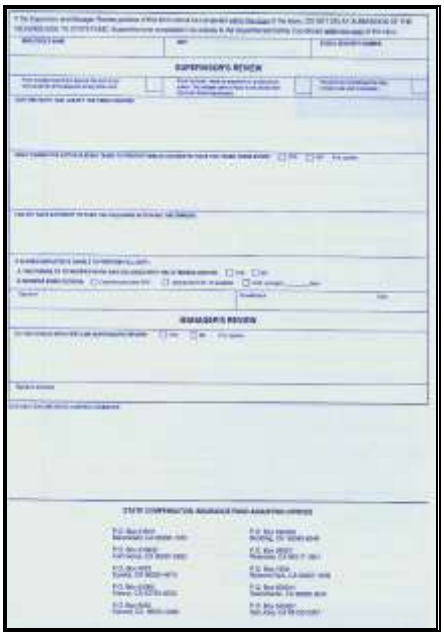
http://www.statefundca.com/statecontracts/Forms.asp

Labor Code 5402

- The Employer has **one working day** after an Employee Claim form is filed to authorize medical treatment.

Labor Code 6409.1

- The Employer will complete and submit an *Employer's Report of Occupational Injury or Illness* (STATE FUND 3067) within 5 working days of knowledge of an injury.



http://www.statefundca.com/statecontracts/Forms.asp

- MUST be completed by supervisor or return-to-work coordinator
- Not an admission of liability
- Employers opportunity to tell what they think
- Not admissible in any proceedings
- Protected under Attorney/Client Privileges
- File via Electronic First Report Of Injury (EFROI) or fax

State Fund Responsibilities

Labor Code 4650

- STATE FUND will make a decision regarding liability and will notify the employee within 14 days of the **Employer's** Knowledge
    - Accept – Pay benefits due
    - Deny
    - Delay – 90 days to make a final decision on liability
        - Obtain Medical treatment records
        - Obtain Medical Evaluation (QME/AME)
        - Pay up to $10,000 in medical benefits (LC5402)

Primary issues related to determining liability

- Labor Code 3600: AOE/COE
- Labor Code 3202: Liberal Construction
- Labor Code 3212-3213.2: Presumptive Injuries or Illnesses
- Medical Substantiation

AOE/COE – in order for a claim to be considered compensable under California Law, both elements must be present

- Injury must **A**rise **O**ut of **E**mployment
- Injury must occur in the **C**ourse **O**f **E**mployment

Liberal Construction -

- Labor Code 3202 – Workers' compensation laws shall be liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment
- LC 3202.5 - Requires all parties meet their evidentiary burden of proof on all issues by a preponderance of evidence and all parties are equal before the law

Presumptive Injuries/Illnesses

- LC 3212 through 3213.2
- Certain state and local public safety members and fire fighters are entitled to a statutory presumption that the condition arose out of and in the course of employment
- Always provide an Employee Claim form (SCIF 3301) if they are subject to any of the following presumptions:
    - Heart Trouble
    - Hernia
    - Tuberculosis
    - Meningitis
    - Low Back (CHP only)
    - Pneumonia
    - Lyme Disease
    - Cancer, Including Leukemia
    - Skin Cancer
    - Bio-chemical Exposure
    - Blood-borne Infections Diseases

Medical Substantiation - Every injury must be medically substantiated (LC5402-ER must authorize medical treatment within one working day)

- **Employer Control** –
  - Chosen doctor/medical facility must be posted in a visible area that is frequented by employees
  - Should be a doctor/medical facility from the MPN

http://www.statefundca.com/statecontracts/Forms.asp

- **Pre-designated treating physician**
  - Employer must provide every employee the opportunity to pre-designate a personal physician or their personal physician's multi-specialty medical group
  - The employee must pre-designate the physician prior to the injury
  - The physician or multi-specialty medical group must agree to be pre-designated
  - Must be a medical doctor (MD) or doctor of osteopathic medicine (DO) that has treated the employee prior to the designation and maintains the employee's medical records

- **Medical Provider Network (MPN)**
  - List of doctors maintained by State Fund
  - All claims with Dates of Injuries of **1/1/06 or later** must treat with a doctor within the network
  - Employers should refer all injured employees (who have not pre-designated) to the MPN

http://www.statefundca.com/claims/MPNHome.asp

Types of Claims

Non-Disability

- Injuries with 3 days or less of medically authorized temporary disability
- Less complex types of injury requiring limited medical oversight
- No permanent disability reasonably expected
- Do not involve legal representation
- Closed or transferred to disability claim within 6 months
- Not used in calculating the State Contract Service Fees

Mini-Disability

- Injuries with over 3 days of medical authorized temporary disability
- Less complex types of injury requiring limited medical oversight
- No permanent disability reasonably expected
- Do not involve legal representation
- Closed or transferred to disability claim within 6 months

Disability

- Injuries with over 3 days of medically authorized temporary disability
- More complex types of injuries
- Most likely will involve permanent disability
- May involve Supplemental Job Displacement Benefit
- May involve legal Representation

Maintenance Claims

- Settled by Stipulation
- Continuing to pay out permanent disability award and/or life pension
- Medical Treatment for the rest of the claimant's life

First Aid Claims

- Does not have to be reported to State Fund (but recommended)
- No time lost from work
- One time visit to a MD plus one follow up for observation of a minor injury only
- Employer MUST pay any medical bills
- Can be filed as Non-disability claim (State Fund will pay medical bills)

Basic Benefits

Benefit Notices

- Sent at the start and stop of every benefit paid to the claimant
- Letters explain the dates paid, the weekly rate calculation and the total benefits paid
- Letters provide explanation of rights and appeal process
- Language is regulated/mandated by the DWC (CA Code of Regs)

Industrial Disability Leave (IDL)

- PERS or STRS members only
- Verified by State Fund according to medical substantiation
- Number of days used tracked by the employer
- Employer pays benefit
- Can use up to 365 days
- Must be used within 2 years from the first date used
- Any partial day counts as 1 full day against 365 day limit
- No WCAB jurisdiction

Labor Codes 4800/4800.5

- 4800 – Department of Justice employees in active law enforcement
- 4800.5 – CHP officers
- Verified by State Fund according to medical substantiation
- Number of days used tracked by the employer
- Employer pays benefit
- Can use up to 365 days
- Can be used for medical appointments and partial days
- Governed by Labor Code so the WCAB has jurisdiction

Temporary Disability (TD)

- Paid by State Fund according to medical substantiation
- The rate is 2/3 of the injured employee's average weekly wage
    - Maximum of $986.69 and minimum of $148.00 per week
- Must be paid within **14 days** of the **Employer Date of Knowledge** that disability exists or IDL/4800/4800.5 is ending, and every 14th day thereafter
    - Paid in 8 hours increments unless there is a wage loss situation
    - Medical appointments not covered by TD

Labor Code 4656

For **dates of injury 4/19/04 thru 12/31/07**

- 2 year limit from the date first paid
- Limit of 104 weeks total
- The one year of IDL counts toward the 2 year limit

For **dates of injury 1/1/08** and later

- Limit of 104 weeks total within 5 years of DOI
- The one year of IDL counts toward the 2 year limit
- Some extreme injuries can extend TD up to 240 compensable weeks
    - Acute and Chronic Hepatitis B & C
    - Amputations
    - Severe Burns
    - HIV
    - High Velocity Injuries
    - Chemical Burn Eye Injuries
    - Pulmonary Fibrosis
    - Chronic Lung Disease
- 2 years of TD after the one year of 4800/4800.5 (Matthews case)

Seasonal TD rates

- Case Law – Jimenez and Signature Fruit
- Allows for two tier TD rates
- In Season rate is 2/3 of average weekly wages
- Off Season rate is 2/3 of weekly off season wages
    - Not subject to minimum TD rates (can be **zero)**
- Agency must notify State Fund of season starting
- State Fund has 14 days from start of season to increase TD rate

Supplemental Job Displacement Benefit (SJDB)

- Dates of injury 1/1/04 and later (replaced Vocational Rehabilitation)
- Employer did not make offer of regular, modified or alternate work within 30 days of TD ending
- Employee did not return to work within 60 days of TD ending
- Claim must be finalized to be paid
- Covers cost of tuition, books, supplies and counselor
- Paid directly to a State Approved or accredited school
- Determined by the PD settlement amount
    - PD 1% - 15%
    - PD 15% - 25%
    - PD 26% - 49%
    - PD 50% - 99%
    - $4000.00
    - $6000.00
    - $8000.00
    - $10,000.00

Permanent Disability

- Starts 14 days after TD/IDL/4800/4800.5 ends or after P&S
- Based on Medical Findings
- Weekly rates vary depending on the percentage of PD, date of injury and the injured workers' earning at the time of the injury. The current maximum is $270.00 per week
- Each PD percentage has an assigned number of weeks of compensation
- The number of weeks and the rate is based on legislation in affect on the date of injury
- The number of weeks can vary from year to year

Life Pension

- Paid on claims with PD ratings of 70% or more
- Starts 14 days after PD ends
- Usually about half of the PD weekly rate
- Paid for the rest of the injured employee's life
- 100**% PD -** the injured employee will receive their **TD rate for the rest of their life**

Medical Treatment

Labor Code 4600

- The Employer must provide medical treatment that is **reasonably required to cure or relieve** the effects of the industrial injury
- Treatment must be reviewed under Utilization Review guidelines
- Allows for a Medical Provider Network (MPN)
    - Injured workers must treat with a doctor in the MPN unless they have pre-designated a physician
    - Chiropractic and Physical Therapy limited to 24 visits each

Medical Control

Utilization Review (UR) – Labor Code 4610

- Treatment must be based on American College of Occupational and Environmental Medicine (ACOEM) or other "Evidence based guidelines"
- Effective for all dates of injury

- Adjusters and nurses can authorize treatment
- Only a doctor can delay, modify or deny a treatment plan
- State Fund has 5 days from receipt to make a determination unless additional information is needed
- Additional information must be requested within 5 days of receipt, State Fund then has 14 days to make a determination.
- If time frames missed
    - **Sandhagen** Case Law - the treatment will be presumed correct
    - Object to the treating physicians findings within 20 days
        - Injured employee must go through the QME process

State Fund UR Program

- District Office Health Consultants in each State Fund office
    - Doctors
    - Chiropractors
    - Nurses
    - Blue Cross and Comp Partners
- If the injured worker disagrees with the Utilization Review decision, they must object and can resolve by QME or AME

Objecting to Medical Findings

- Must object within 20 days of receipt of the medical report
    - Can be extended on represented cases if both parties agree
- Either party can object
    - Extent and Scope of treatment
    - Existence of New and Further disability
    - Permanent and Stationary status
    - Inability to engage in usual occupation

Qualified Medical Evaluator (QME)/Agreed Medical Evaluator (AME)

- Once a Primary Treating Physician (PTP) finds the injured employee to be permanent and stationary (P&S), State Fund and the Claimant/Applicant's Attorney (AA) have 20 days to agree or object to the findings.
- **If all parties** agree**, the case will be worked up for a settlement authority request.**
- **If either party** disagrees**, the parties must proceed through the AME/QME process.**

Unrepresented –

- If **State Fund agrees** with the PTP, but the **injured disagrees** – the injured employee completes a Request for a Panel QME
    - to the DWC (Division of Workers' Compensation)
    - The DWC issues a panel of 3 doctors
    - The injured employee has 10 days from receipt to pick a doctor and schedule an evaluation.
- If **State Fund disagrees** with the PTP, whether the injured agrees or not – the injured employee has 10 days to complete the Request for a Panel QME
    - to the DWC (Division or Workers' Compensation)
    - If the injured employee does not comply, State Fund completes the request
    - DWC issues a panel of 3 doctors
    - The injured employee has 10 days to pick a doctor and schedule an evaluation
    - If they do not choose a doctor, then State Fund can choose the doctor and schedule the evaluation

Represented –

- If **either party disagrees**
    - Either party can object within 20 days (or if agreed upon by both parties, a longer period of time)
    - If objecting, an AME offer must be made
    - If a doctor can be agreed upon, that doctor makes all the final determinations on the file.
- If a doctor **can not be agreed upon**
    - Either party can request a panel of QME doctors
    - The DWC issues a panel of 3 doctors
    - Once panel received, each party has three days to strike one doctor from the list
    - The last doctor left on the list is the chosen QME. This process has been coined "the last doc standing"
    - If either party fails to strike a doctor timely, the other party may just pick a doctor and schedule an evaluation
    - This doctor makes all the future and final determinations on the file.

Permanent Disability

Permanent and Stationary

- Residual effects of an industrial injury as ascertained and described by physicians when the employee's condition becomes "**permanent and stationary**" or has reached "**maximum medical improvement**"
    - A condition is considered "P&S" or "MMI" when it has **stabilized and is unlikely to change in the next year.**
- Physicians provide information about the injured employee's permanent impairments and limitations
- Medical findings and conclusions are translated into a permanent disability rating based on procedures and benchmarks set forth by the Labor Code and the Permanent Disability Rating Schedule

PD Ratings

- PD ratings are based the objective findings of the physician.
- The physician is required to measure the medical history and objective findings against the **Activities of Daily Living**
- The physician is required to report an impairment using the **American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th edition).**
- The impairment standard provided by the physician in terms of Whole Person Impairments (WPI)
- The adjuster adjusts the impairment to account for the diminished future earning capacity, age and occupation

The Activities of Daily Living:

- Self Care
- Communication
- Physical Activity
- Sensory Function
- Non-specialized hand activities
- Travel
- Sexual Function
- Sleep

Impairment vs. Disability

Impairment – loss, loss of use or derangement of any body part, organ system or organ function

Disability – effect of impairment on the ability to meet personal, social or occupational demands

Ratings can range from 0% to 100%

- Zero percent signifies no reduction in their ability to meet personal, social or occupational demands
- 100% represents *legal* total disability. Total disability does not mean that the employee cannot work, but rather represents a level of disability at which they would not normally be expected to be able to successfully meet personal, social or occupational demands.

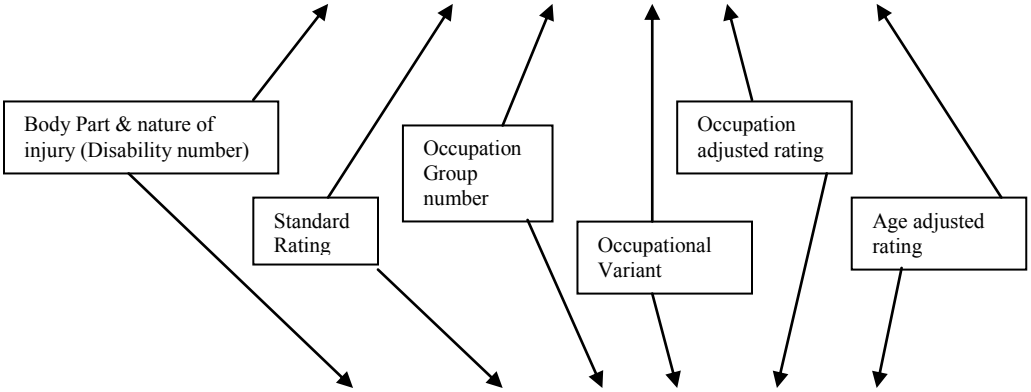
Three Schedules for Permanent Disability Rating (PDR)

- The first was developed in 1914 and revised in 1978
- The second schedule was adopted April 1, 1997
- The third PDR was adopted by emergency regulations on 1/1/05.

The following examples are for a 50 year old safety officer with a low back injury.

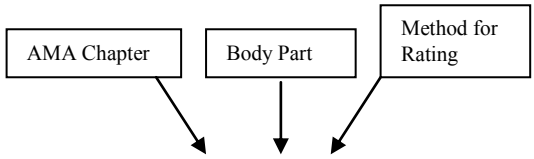
Old Formulas

Prior to 1997 - 8.1 – 10 – 54 – H – 13 – 15:0

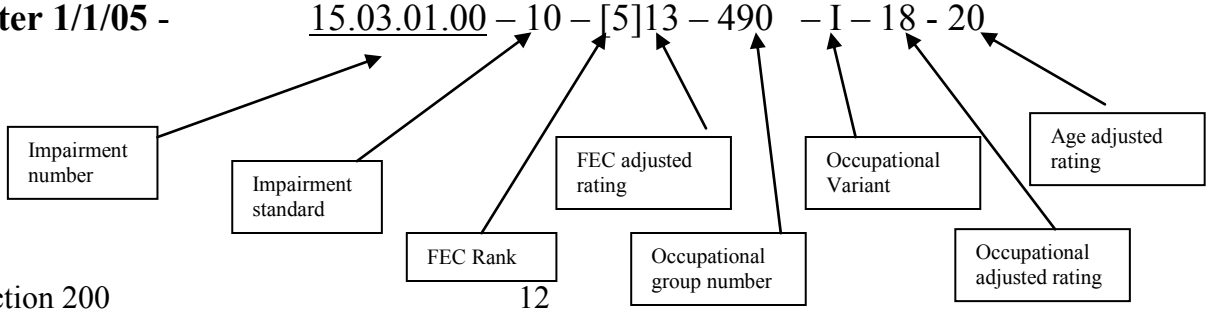


4/1997 – 12/2004 - 12.1 – 10 – 490 – I – 15 – 17

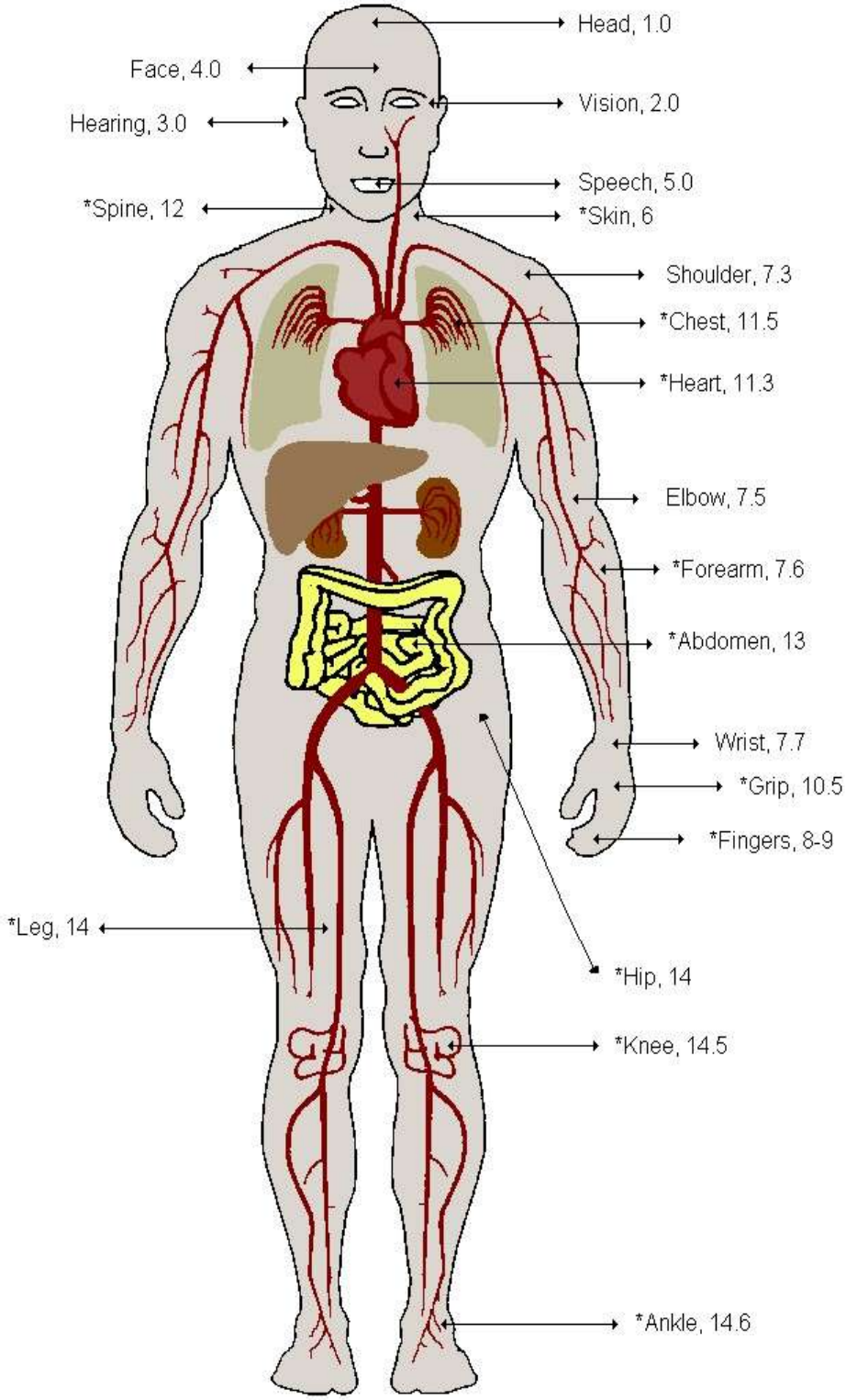
New Formula



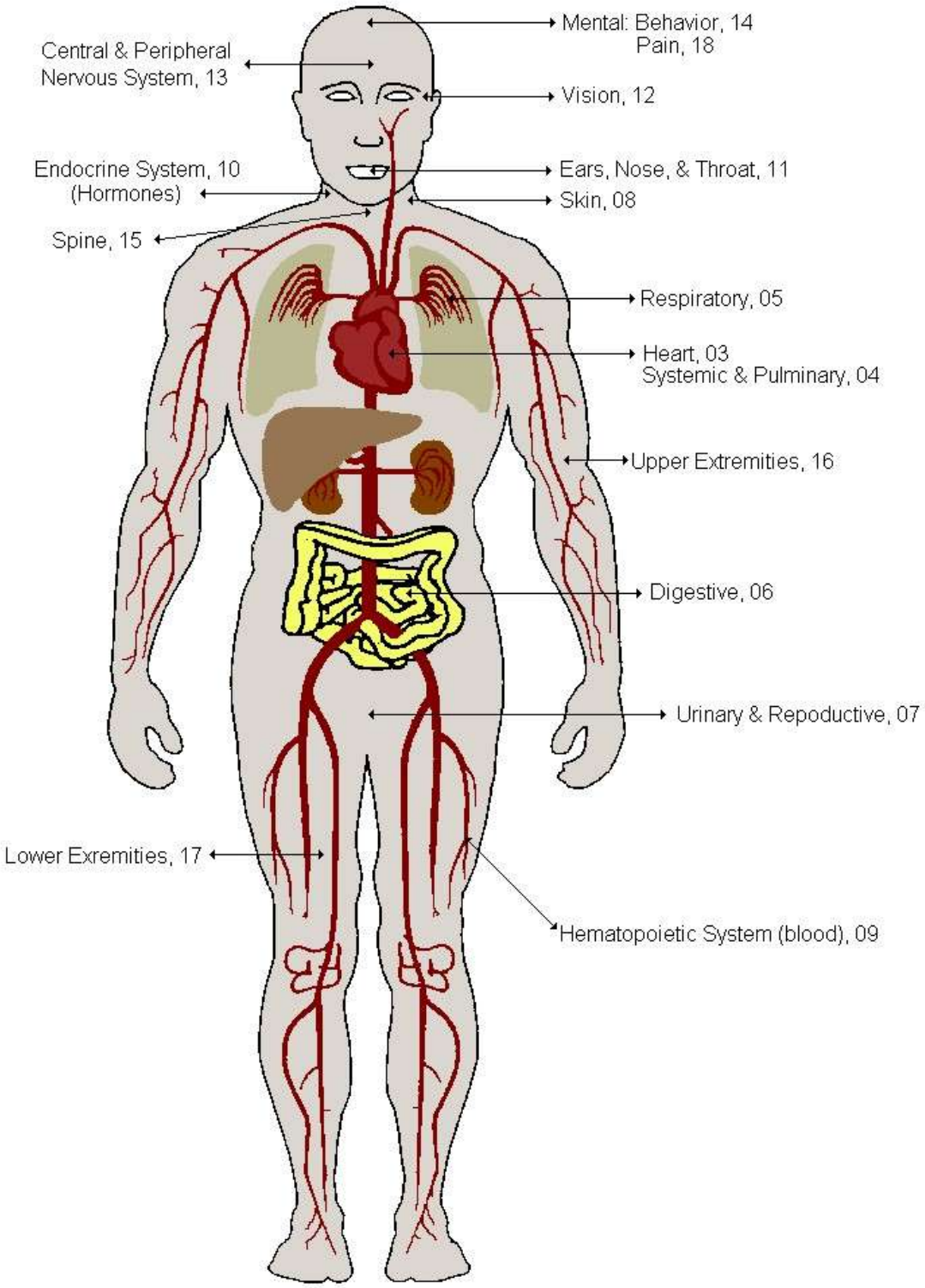
After 1/1/05 - 15.03.01.00 – 10 – [5]13 – 490 – I – 18 - 20



PERMANENT DISABILITY: Anatomical Drawing fro DOI April 1, 1997+



PERMANENT DISABILITY: Anatomical Drawing for DOI after 1/1/05



Apportionment

- Physician determines what percentage of the impairment was caused by the industrial injury
- This percentage is subtracted from the total disability and the employer is held responsible for only the portion caused by the industrial injury
- 7 regions of the body – each region can receive up to 100% PD
- Labor Code 4663 -provides that the physician determines the percentage caused by any pre-existing non industrial injuries and/or conditions
- Labor Code 4664 - any pre-existing workers' compensation settlements will be **conclusively presumed** still in tact and will be apportioned (percentage of prior award subtracted from new disability percentage – Welcher/Brodie Supreme Court decision).
- Presumptions can not apportion to non-industrial factors when there is an anti-attribution clause
- Benson – Wilkinson no longer applies – apportion to each case

Disability Evaluations Unit

- Rating specialists at each WCAB office that provide disability ratings
- Three types of ratings
    - Summary Rating
        - Issued on non-represented claims
        - Not mandatory for settlement, but Judges require you prove one was requested
        - Can be issued on a PTP report or a panel QME report
        - Not binding on either party, but they are difficult to fight
    - Formal Rating
        - Issued on litigated cases at the request of the Workers' Compensation Judge usually during trial proceedings
    - Consultative Rating
        - Not an official rating
        - Merely advisory and is usually obtained to assist in settling a claim
        - May be obtained regardless of legal representation
        - Not admissible in a judicial proceeding

+/- 15% for Regular, Modified or Alternative Work

Labor Code 4658(d) - For injuries occurring on or after 1/1/05

For "Large Employers" with 50 or more employees – State agencies are all considered to be "large employers"

- Permanent Disability weekly payments after P&S will be reduced or increased depending on whether the employer can offer the injured employee regular, modified or alternative work with in **60 days of a disability becoming permanent and stationary.**
- All offers of regular, modified or alternative work are governed by the definitions of Labor Code §4658.1
- All offers must be on form DWC 10003 or DWC 10133.53
- The Wage and compensation for any increase in working hours over the average hours worked at the time of injury shall not be considered.
- The employee may waive the condition that regular, modified or alternative work be located within a reasonable distance of the employee's residence at the time of injury
- The condition is waived if the employee accepts regular, modified or alternative work and does not object to the location within 20 days of being informed of the right to object.
- The condition is conclusively deemed satisfied if the offered work is at the same location and same shift as the employment at the time of injury.

Regular Work

- Usual occupation or the position in which the employee was engaged at the time of injury and that offers wages and compensation equivalent to those paid to the employee at the time of the injury and located within a reasonable commuting distance of the employee's residence

Modified Work

- Regular work modified so that the employee has the ability to perform all the functions of the job and that offers wages and compensation that are at the least 85% of those paid to the employee at the time of injury and located within a reasonable commuting distance of the employee's residence at the time of injury

Alternative Work

- Work that the employee has the ability to perform, that offers wages and compensation that are a least 85% of those paid to the employee at the time of injury, and that is located with a reasonable commuting distance of the employee's residence at the time of injury

Increase vs. Decrease

- If within **60 days** of a disability becoming P&S, an **employer does <u>not</u> offer an injured employee regular, modified or alternative work for a period of at least 12 months**, each disability payment remaining to be paid from the date of the 60 day period shall be ***increased by 15%.***

  Example: If the base rate is $230/week, the payment will be increased to $264.50/week (15% more).

- If within **60 days** of a disability becoming P&S, an **employer offers an injured employee regular, modified or alternative work for a period of at least 12 months**, and regardless of whether the offer is accepted or rejected, each disability payment remaining to be paid from the date the offer was made will be ***decreased by 15%.***

  Example: If the base rate is $230/week, the payment will be decreased to $195.50/week (15% less).

- If the **employer terminates the regular, modified or alternative work** before the end of the period for which disability payment are due, the amount of each of the remaining payment shall ***increase 15%.***

  Example: If the base rate was $230/week but this is initially reduced to $195.50/week (15% less) due to an offer of regular, modified or alternative work, the remaining benefits would be paid at $264.50/week.

- If an **employee voluntarily** quits then he/she will not be eligible for 15% increase of the remaining weeks of PD benefits from the time of leaving employment.

  Example: If the base rate if $230/week, payment will continue to be paid at $195.50/week (15% less). Payments will **not** revert back to the base rate of $230/week.

Settlement Process

Authority Requests

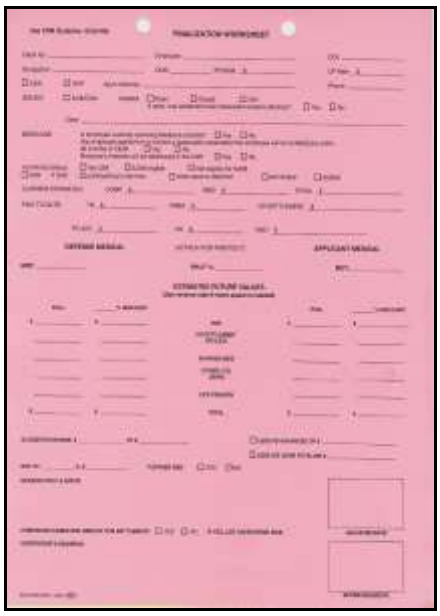
- State Fund will request authority from the employer when medical file is complete
    - Reports addressing permanent and stationary, permanent disability and apportionment
- Estimate the value of the claim
    - Permanent disability
    - Future Medical treatment
    - Any outstanding TD issues
    - Any outstanding medical liens
- Prepare a finalization worksheet
- Prepare an authority request
- Send it to the RTWC

Employer has 10 days from receipt to authorize the authority request or state any objections

- If there is not a timely response, State Fund can assume authority

The Authority requests will include:

Proposed Finalization for State Cases (Authority Request)



Finalization Worksheet

Estimate

Balance Sheet

State Fund Rating (DOI Pre- 1/1/05)

OR…

STATE FUND Rating (DOI Post 1/1/05)

California PD Report

Date of Injury: 01/14/2005
Date of Birth: 06/15/1965 Age at DOI: 39
Occupation: Correction Offi Group No.: 490
Average Weekly Earnings: $1,200.00

Lumbar – Diagnosis-related Estimate
15.03.01.00 - 10 - [5] 13 - 490I - 18 - 18
Cervical – Range of Motion – Spondylolysis, no operation
80%(15.01.02.03 - 6 - [5] 8 - 490I - 12 - 12) 10

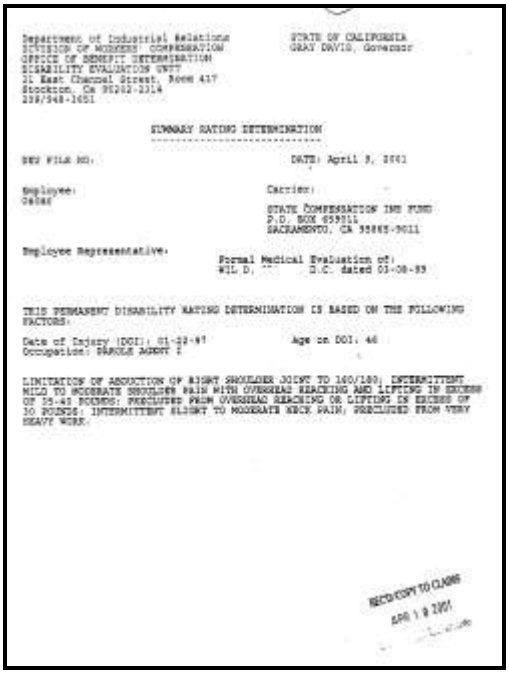
Lumbar – Diagnosis-related Estimate(18)
Cervical – Range of Motion – Spondylolysis, no operation(10)

18 combined with 10 = 26
----
26 % = $220.00 per week * 106.75 weeks = $23,485.00

If L.C. 4658(d)(2-3) applies:
*** the weekly rate increased by 15% = $253.00**
*** the weekly rate decreased by 15% = $187.00**

OR…

DEU Summary Rating



Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION
OFFICE OF BENEFIT DETERMINATION
DISABILITY EVALUATION UNIT
31 East Channel Street, Room 417
Stockton, CA 95202-2314
209/948-3651

STATE OF CALIFORNIA
GRAY DAVIS, Governor

SUMMARY RATING DETERMINATION

DEU FILE NO.

DATE: April 9, 2001

Employee:
Cabaz

Carrier:
STATE COMPENSATION INS FUND
P.O. BOX 659811
SACRAMENTO, CA 95865-9011

Employee Representative:

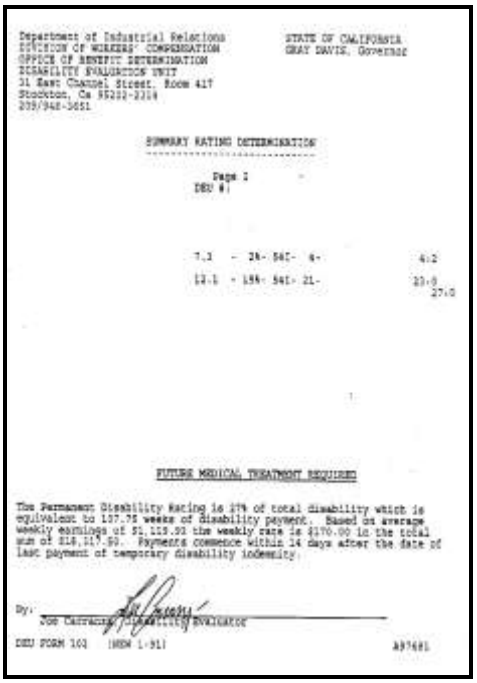
Formal Medical Evaluation of:
WIL D, ... D.C. dated 03-08-99

THIS PERMANENT DISABILITY RATING DETERMINATION IS BASED ON THE FOLLOWING FACTORS:

Date of Injury (DOI): 01-22-97
Occupation: PAROLE AGENT I
Age on DOI: 46

LIMITATION OF ABDUCTION OF RIGHT SHOULDER JOINT TO 160/180; INTERMITTENT MILD TO MODERATE SHOULDER PAIN WITH OVERHEAD REACHING AND LIFTING IN EXCESS OF 35-40 POUNDS; PRECLUDED FROM OVERHEAD REACHING OR LIFTING IN EXCESS OF 30 POUNDS; INTERMITTENT SLIGHT TO MODERATE NECK PAIN; PRECLUDED FROM VERY HEAVY WORK.

RECD COPY TO CLOSE
APR 19 2001



Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION
OFFICE OF BENEFIT DETERMINATION
DISABILITY EVALUATION UNIT
31 East Channel Street, Room 417
Stockton, CA 95202-2314
209/948-3651

STATE OF CALIFORNIA
GRAY DAVIS, Governor

SUMMARY RATING DETERMINATION

Page 2
DEU #:

7.3 - 28- 54[- 6- 4:2
12.1 - 15%- 54[- 21- 33.0
27.0

FUTURE MEDICAL TREATMENT REQUIRED

The Permanent Disability Rating is 27% of total disability which is equivalent to 107.75 weeks of disability payment. Based on average weekly earnings of $1,115.93 the weekly rate is $170.00 in the total sum of $18,317.50. Payments commence within 14 days after the date of last payment of temporary disability indemnity.

By: _____
Joe Carrasco, Disability Evaluator

DEU FORM 103 (REV 1-91) A97681

Things to Consider Prior to Settlement

Labor Code 5814 Penalties

- Up to 25% of late payment
- If 10% self-imposed penalty paid by State Fund within 90 days of knowledge - no additional penalty can be awarded

Labor Code 132A

- The employer can not discriminate against the employee as a result of filing a workers' compensation claim
- The penalty is one-half the value of the claim (all species of benefits - TD, PD, VR & Medical - past, present and future), in addition to all entitled benefits, up to $10,000

Serious and Willful (S&W)

- Labor Code 4553
- An employers knowledge of a hazard prior to an injury may expose the Department to a S&W
- The penalty is one-half the value of the claim (all species of benefits - TD, PD, VR & Medical - past, present and future), in addition to all entitled benefits
- No limit

Subrogation

- Third party liability claims
    - Motor Vehicle Accidents
    - Defective Products
        - Chairs, elevators, equipment, etc…
- Will be filed if the claimant personally files suit against the third party
- Subrogation Legal Unit
- Recovery
    - Cash – deposited back to the case
    - Statutory Credit
        - State Fund takes credit for any further benefits due
        - Injured must provide receipts for medical treatment

Liens

- EDD
- Child Support
- Medical
    - Provider can file a lien within
        - 6 months from the date of settlement
        - 5 years from the date of injury
        - 1 year from the date services were provided
          Whichever is later

Medicare Set-Aside

- C&Rs only
    - Needed on all C&R's over $250,000 and will be on Medicare in the next 30 months
- If currently on Medicare-
    - All C&Rs must have a set aside account
    - Only those over $25,000 are submitted to CMS for approval

Mandatory Settlement Conference (MSC)

- If State Fund is unable to settle the claim it proceeds into the litigation process.
- Declaration of Readiness (DOR)
    - Offer of settlement must be made prior to filing a DOR
    - Parties must object to a DOR within 10 days, if it is needed
    - MSC will be scheduled by the WCAB regardless of objection
- Preparation for an MSC
    - State Fund will request authority
    - List of Witnesses
    - All exhibits to be presented at trial
        - Medical
        - Investigation
        - Subrosa tapes
        - Personnel records
        - Misc. Documentation
- Goal of the MSC is to settle and resolve all issues.
- If we are unable to settle, the case will be set for trial
    - Discovery will be closed by the Judge
    - No further evidence can be submitted

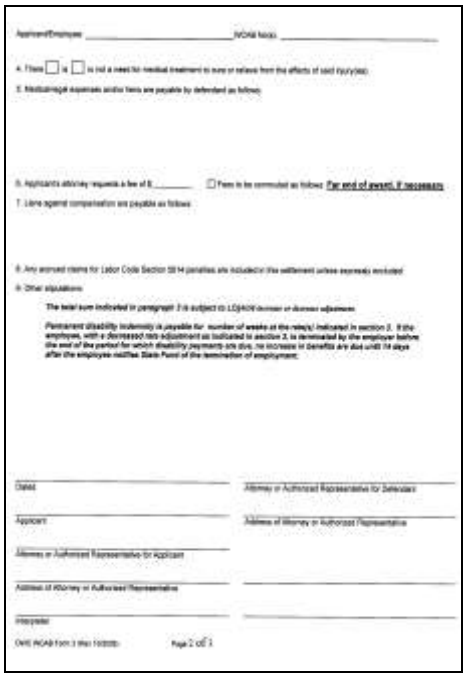
Claims Resolution

Stipulations with Request for Award (stips)

- Settles the permanent disability – parties agree to a percentage of disability
- PD paid out every two weeks
- LP there after (if due) for the rest of the claimant's life
- Leaves Future medical open for the rest of the claimants life

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

STIPULATIONS WITH
REQUEST FOR AWARD



AWARD

Compromise and Release (C&R)

- Usually buys out all benefits due (include PD and future medical) for one lump sum to be paid out immediately
- Not usually considered if the employee continues to work for the same employer

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

COMPROMISE AND RELEASE

WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

Order Approving
Compromise and Release

Findings and Award (F&A)

- Determined by the Judge
- Findings based on evidence and testimony presented at trial
- Parties have 20 days to object to the findings
    - File a Petition for Reconsideration (Recon)
    - If the Petition is not granted, parties file an Appeal
    - Reviewed at the Appellate Court Level
    - If we disagree with those finding we file a Writ of Certiorari
    - Reviewed at the Supreme Court Level

Dismissal

- Filed on litigated files when the applicant attorney fails to complete their discovery
- State Fund must notify all parties of intent to dismiss
- Parties have 20 days to file an objection with the DWC
- Judge reviews and issues a determination
    - The judge will allow an additional 10 days for an objection before the decision is final

Closing Claims

Non-represented claims with no activity

- Adjuster must send a closing notification
- Close in 6 months

Represented claims

- Can not be closed until settled

Settled Claims

- Stipulations and F&As
    - After all benefits have been paid out in full (IDL, TD, PD, LP, VR)
    - All liens are settled and paid
    - Minimal medical treatment in the last 12 months (4 bills or $1,000)
- C&R and Dismissals
    - Immediately after settlement is paid
    - All Liens are settled and paid